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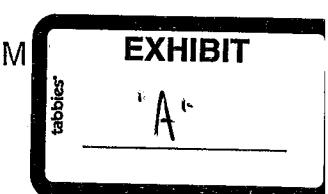


NOTICE

THIS IS IMPORTANT TO YOU
Please keep this attached to your benefits booklet.

Revisions to the Mental Health Care Services and Substance Abuse Service Benefits effective April 1, 2007

A definition for Partial Hospitalization is added to the Terms You Should Know section.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

In the Covered Services section, benefit descriptions for Mental Health Care Services and Substance Abuse Services are revised as follows (see Summary of Benefits for applicable program limits or cost-sharing provisions):

Partial Hospitalization Mental Health Care Services
Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed to be an outpatient care visit, will accumulate against any outpatient mental health visit limit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider when you are an outpatient. Once you have exhausted your benefit period outpatient care visits, additional outpatient care visits may be obtained in exchange for each unused inpatient care day on a two-for-one basis.

Substance Abuse Services
For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and will accumulate against the outpatient substance abuse visit limit and is subject to any outpatient care cost-sharing amounts.

Table of Contents

Disclosure

Your health benefits are entirely funded by your employer. Highmark Blue Shield provides administrative and claims payment services only.

Introduction to Your PPOBlue℠ Program

This booklet provides you with the information you need to understand your PPOBlue program offered by your group. We encourage you to take the time to review this information so you understand how your health care program works.

For a number of reasons, we think you'll be pleased with your health care program:

- ***Your PPOBlue program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. PPOBlue gives you access to the largest provider network of physicians, hospitals, and other providers in Central Pennsylvania and the Lehigh Valley, as well as providers across the country who are part of the local Blue Cross and Blue Shield PPO network. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, check your provider directory or log onto Highmark Blue Shield's Web site, www.highmarkblueshield.com.

- ***Your PPOBlue program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can save you time and medical expenses down the road.

And, as a member of your PPOBlue program, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Call℠, the Highmark Blue Shield Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to give you a "Greater Hand" in your health by helping you make and maintain healthy improvements.

You can review Preventive Care Guidelines, check eligibility information, order ID cards, medical and drug claim forms, even review claims and Explanation of Benefits (EOB) information all online. You can also access health information such as the comprehensive Healthwise Knowledgebase®, full-color Health Encyclopedia, and the Health Crossroads® guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

If you have any questions on your PPOBlue program please call the Member Service toll-free telephone number on the back of your ID card.

As always, we value you as a member, look forward to providing your coverage, and wish you "good health."

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Your benefit period is a calendar year starting on January 1.

Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms " copayment," "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment is the specific, upfront dollar amount you pay for certain covered services which will be deducted from the provider's reasonable charge. You may be responsible for multiple copayments per visit. See your Summary of Benefits for the copayment amounts.

The copayment does not apply toward your deductible or coinsurance, and does not accumulate toward the out-of-pocket limit. **You are expected to pay your copayment to the provider at the time of service.**

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

When two or more covered family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

Inpatient Deductible per Admission

The inpatient deductible per admission is the amount of expense you must pay for medically necessary and appropriate health care for each admission to a hospital before the program begins to pay all or part of the remaining expenses.

Your inpatient deductible per admission is specified in the Summary of Benefits. It applies to each covered person per admission.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, mental health/substance abuse expenses or amounts in excess of the provider's reasonable charge.

Family Out-of-Pocket Limit

The family out-of-pocket limit refers to the amount of coinsurance incurred by you or your covered family members for covered services received in a benefit period.

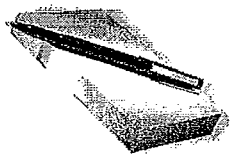
Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the

remainder of the benefit period will be payable at 100% of the provider's reasonable charge.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your out-of-pocket limit during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial benefit period under this program.

Maximum

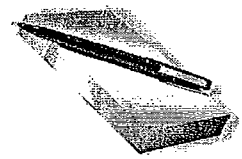
The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.



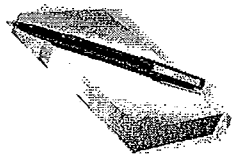
Summary of Benefits

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family *(Aggregate)*	 None None	 $250 $500
Plan Payment Level - Based on the provider's reasonable charge (PRC)	90% PRC , until out-of-pocket limit is met; then 100% PRC	60% PRC after deductible, until out-of-pocket limit is met; then 100% PRC - Professional; 60% of charges after deductible until out-of-pocket limit is met; then 100% PRC - Facility
Out-of-Pocket Limits Includes Coinsurance. See the section "How Your Benefits Are Applied" for exclusions/details Individual Family *(Aggregate)*	 $1,500 $3,000 (accumulates to out-of-network out-of-pocket maximum)	 $3,900 $7,800
Lifetime Maximum (per member)	Unlimited	Unlimited
Ambulance Service	90% PRC	60% PRC after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	90% PRC	60% PRC after deductible
Diabetes Treatment	90% PRC	60% PRC after deductible
Diabetic Supplies	90% PRC	90% of charges; deductible does not apply
Diagnostic Services ***Advanced Imaging Services*** - *MRI, CAT Scan, PET Scan etc* *Basic Imaging Services*	90% PRC after $25 copayment per date of service 90% PRC	60% PRC after deductible
Basic Diagnostic Services - *Diagnostic Medical, Lab/Pathology and Allergy Testing*	90% PRC after $5 copayment per date of service/type of service	60% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% PRC	60% PRC after deductible
Emergency Care Professional	90% PRC; deductible does not apply	60% PRC; deductible does not apply
Emergency Room Services Facility Services	100% PRC after $150 copayment (waived if admitted)	



Benefits	Network	Out-of-Network
Urgent Care Services	100% PRC after $75 copayment	60% PRC after deductible
Enteral Formulae	90% PRC; deductible does not apply	60% PRC deductible does not apply
Hearing Care Services (routine every two years)	100% PRC after $20 copayment	Not Covered
Home Health Care[1] Excludes Respite Care	90% PRC	60% PRC after deductible
	120 visits per benefit period	
Hospice Care Includes Respite Care	90% PRC	60% PRC after deductible
	$5,000 per lifetime	
Hospital Services		
Inpatient Deductible	$100 per admission	$100 per admission
Inpatient	90% PRC after inpatient deductible	60% PRC after inpatient deductible; program deductible does not apply
Outpatient[2]	90% PRC	60% PRC after deductible
	365 days	
Infertility Counseling, Testing and Treatment[3]	90% PRC	60% PRC after deductible
Maternity (facility and professional services) Includes Dependent Daughters	90% PRC	60% PRC after deductible
Medical Care Includes Inpatient Visits and Consultations	90% PRC	60% PRC after deductible
Mental Health Care Services - Inpatient	90% PRC (Inpatient admission coinsurance accumulates toward the network out-of-pocket maximum)	60% PRC after deductible
	30 days per benefit period	
Mental Health Care Services - Outpatient	100% PRC after $30 copayment	50% PRC after deductible
	20 visits per benefit period	
Office Visits		
Primary Care Physician[4]	100% PRC after $20 copayment	60% PRC after deductible
Specialty Care Physician	100% PRC after $20 copayment	60% PRC after deductible
Oral Surgery	90% PRC	60% PRC after deductible
Physical Medicine Outpatient	100% PRC after $20 copayment	60% PRC after deductible
	Combined Limit: 60 visits per benefit period combined with Speech & Occupational therapy and Spinal Manipulations	



Benefits	Network	Out-of-Network
Preventive Care		
Adult Routine Physical Exams	100% PRC after $20 copayment	Not Covered
Adult Immunizations	100% PRC	Not Covered
Routine Diagnostic Screening	90% PRC	Not Covered
Mammograms One baseline between age 35-40 - annually age 40+	100% PRC	Not Covered
Routine gynecological exams, including a PAP Test	100% PRC after $20 copayment	Not Covered
Pediatric		
Routine Physical Exams	100% PRC after $20 copayment	Not Covered
Pediatric Immunizations	100% PRC	Not Covered
Routine Diagnostic Screening	90% PRC	Not Covered
Private Duty Nursing	90% PRC	60% PRC after deductible
	Unlimited hours/benefit period	
Skilled Nursing Facility Care	90% PRC	60% PRC after deductible
	60 days per benefit period	
Speech & Occupational Therapy Outpatient	100% PRC after $20 copayment	60% PRC after deductible
	60 visits per benefit period/per type of therapy combined with Spinal Manipulations and Physical Medicine	
Spinal Manipulations	100% PRC after $20 copayment	60% PRC after deductible
	60 visits per benefit period combined with Speech & Occupational Therapy and Physical Medicine	
Substance Abuse Services - Detoxification	90% PRC (Inpatient admission coinsurance accumulates toward the network out-of-pocket maximum)	60% PRC after deductible
	7 days per admission	
Substance Abuse Services - Inpatient Rehabilitation	90% PRC (Inpatient admission coinsurance accumulates toward the network out-of-pocket maximum)	60% PRC after deductible
	30 days per benefit period	
Substance Abuse Services - Outpatient [5]	90% PRC after $30 copayment	50% PRC after deductible
	20 visits per benefit period	

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Benefits	Network	Out-of-Network
Surgical Expenses Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures Excludes Neonatal Circumcision	90% PRC	60% PRC after deductible
Therapy and Rehabilitation Services (Cardiac Rehabilitation, Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy and Respiratory Therapy)	90% PRC	60% PRC after deductible
Transplant Services	90% PRC	60% PRC after deductible
Precertification Requirements	Yes[6]	
Condition Management	Case Management and Blues on Call	

1 The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

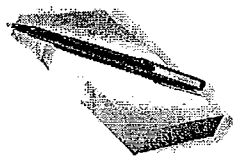
2 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

3 If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

4 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

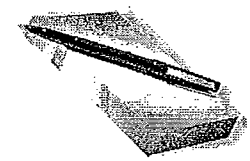
5 Of the 60 outpatient visits or equivalent partial visits or partial hospitalization services per benefit period, a maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per benefit period beyond the 30-day limit for inpatient non-hospital rehabilitation services.

6 Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency admission or maternity-related admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.



Preventive Care Schedule of Covered Services

Adult Preventive Services	
Periodic Physical Exam 19-64 years - once every 24 months	65 years and older - annually
Fecal Occult Blood Test 40 years and older - annually	
Blood Cholesterol Test (HDL) 19-49 years - once every five years	50 years and older - annually
Adult Tetanus and Diphtheria Booster 19 years and older - once every 10 years	
MMR 19-39 years - no limits	
Influenza Vaccine 50 years and older - annually	
Pneumococcal Vaccine 65 years and older - once every five years	
Urinalysis 19-64 years - once every five years	65 years and older - annually
Hemoglobine/Hematocrit 19-64 years - once every 24 months	65 years and older - annually
Flexible Sigmoidoscopy 50 years and older - every 3 years	
Prostatic Specific Antigen (PSA) 40 years and older - annually	
Screening Mammography 40 years and older - annually	
Routine Gynecological Exam and Pap Smear No age limit - annually	
Hepatitis B Vaccine 19-39 years (unlimited)	
HPV Vaccine (Gardisill) 19-26 years	
Vanricella Vaccine Unlimited	
EKG 40-65 years - one time	
Colonoscopy 50 years and older - annually	



Preventive Care Schedule of Covered Services

Pediatric Preventive Services				
Periodic Physical Exam				
0-1 month	3 years			
2-3 months	4 years			
4-5 months	5 years			
6-8 months	6 years			
9-11 months	7-18 years (every 24 months)			
12-14 months				
15-17 months				
18-24 months				
Urinalysis				
Once during each age range				
Birth - 24 months	2-6 years	7-12 years	13-18 years	
Hemoglobin/Hematocrit				
Once during each age range				
Birth - 24 months	2-6 years	7-12 years	13-18 years	
Tuberculosis (TB) Test				
Once during each age range				
Birth - 24 months	2-18 years			
Childhood Immunizationss recommended by your physician such as:				
Diphtheria/Tetanus/Pertussis (DTP)				
Hemophilus (Hib)				
Polio				
Measles/Mumps/Rubella (MMR)				
Varicella (Chicken pox) - Second Dose Vaccine Ages 4-6 years				
Hepatitis B				
Hepatitis A				
Rotovirus				
HPV Vaccine (Gardisil) - 9-18 years				
Influenza Vaccine				
Once during age range				
6 months-59 months				

Covered Services - Medical Program

PPOBlue provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits. Network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility; or
- between hospitals; or
- between a hospital and a skilled nursing facility;

when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then you are covered for ambulance service to the closest facility outside your local area that can provide the necessary service.

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist which are required as the result of accidental injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered accidental injury.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
  - Visits medically necessary and appropriate upon the diagnosis of diabetes

- Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes

*__Diabetes Education Program__ – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark Blue Shield's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health.

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

- **Standard Imaging Services** - procedures such as skeletal x-rays, ultrasound and fluoroscopy
- **Laboratory and Pathology Services** - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
- **Diagnostic Medical Services** - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing
- **Allergy Testing Services** - allergy testing procedures such as percutaneous, intracutaneous, and patch tests
- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests

- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, at the option of Highmark, the purchase, adjustment, repair and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider, within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits are exempt from all deductible requirements.

Hearing Care Services

Benefits include coverage for, an audiometric examination, when prescribed by a professional provider.

Home Health Care Services

This program covers the following services you receive from a home health care agency or a hospital program for home health care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*, excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care

- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services

* The services of an LPN shall be made available only when the services of an RN are not available and only when medically necessary and appropriate. Services of an LPN are only reimbursable through a facility provider.

No home health care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care; and
- food or home-delivered meals.

Home Infusion Therapy Services

Benefits will be provided when performed by a home infusion therapy provider in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Hospice Care Services

This program covers the following services you receive from a home health care agency or a hospital program for hospice care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*, excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care
- Oxygen and its administration

- Medical social service consultations
- Health aide services when you are receiving covered nursing services or therapy and rehabilitation services
- Respite care
- Family counseling related to the member's terminal condition

* The services of an LPN shall be made available only when the services of an RN are not available and only when medically necessary and appropriate. Services of an LPN are only reimbursable through a facility provider.

No hospice care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care; and
- food or home delivered meals.

Hospital Services

This program covers the following services you receive in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Bed and Board

Bed, board and general nursing services are covered when you occupy:

- a room with two or more beds;
- a private room; or
- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Surgery

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, and anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Pre-Admission Testing

Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Emergency Care Services

As a PPOBlue member, you're covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately*.

Your outpatient emergency room visits may be subject to a copayment, which is waived if you are admitted as an inpatient. (Refer to the Summary of Benefits for your program's specific amounts.)

Please keep in mind, however, if your care is determined not to be an emergency and you receive care at an out-of-network hospital, you may be responsible for

your program's deductible and coinsurance amounts, resulting in your benefits being paid at the lower out-of-network level.

In true emergency situations where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency Accident Care

Services and supplies for the outpatient emergency treatment of bodily injuries resulting from an accident.

Emergency Medical Care

Services and supplies for the outpatient emergency treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention and with which the absence of immediate medical attention could reasonably result in:

- placing the patient's health in jeopardy;
- causing serious impairment to bodily functions;
- causing serious dysfunction of any bodily organ or part; or
- causing other serious medical consequences.

Maternity Services

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital that is covered at the higher level of benefits.

This program provides services rendered by a facility provider or professional provider for:

Complications of Pregnancy

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Normal Pregnancy
Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Nursery Care
Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days.

Under Federal law, your self-insured group health program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Services

Inpatient Medical Services

Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

Consultation

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations.

Inpatient Medical Care Visits

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient. Benefits will continue for a maximum of 31 days.

Outpatient Medical Care Services (Primary Care Physician Visits)
Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Therapeutic Injections
Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Mental Health Care Services

Your mental health is just as important as your physical health. That's why PPOBlue provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. PPOBlue covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services
Inpatient hospital services provided by a facility provider for the treatment of mental illness.

Inpatient Medical Services
Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy

- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider.

Partial Hospitalization Mental Health Care Services

Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by Highmark and is offered by a facility provider or professional provider. Such programs are subject to periodic review by Highmark.

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical service benefits as described in this section and are also available when provided by a facility provider or professional provider for the outpatient treatment of mental illness.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Preventive Care Services

PPOBlue provides excellent coverage for your network preventive care. This vital care can help you stay on top of your medical needs and establish a healthy, well-informed lifestyle.

That's why we encourage you to take advantage of our excellent preventive care benefits, including periodic physical examinations, well child visits, and a full scope of diagnostic testing such as cholesterol screenings, gynecological exams, and Pap tests. These preventive benefits are offered in accordance with a predefined schedule based on age and sex. Highmark periodically reviews the schedule of covered services based on recommendations from organizations such as the American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force, the American Cancer Society and the Blue Cross and Blue Shield Association. Therefore, the frequency and eligibility of services is subject to change.

Adult Care
Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history.

Adult Immunizations
Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Routine Gynecological Examination and Pap Test
All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Mammographic Screening
Benefits are provided for the following:

- An annual routine mammographic screening for all female members 40 years of age or older.
- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Care
Routine physical examinations, regardless of medical necessity and appropriateness.

Pediatric Immunizations
Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

Allergy Extract/Injections
Benefits are provided for allergy extract and allergy injections.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home, only when Highmark determines that the nursing services require the skills of an RN or of a LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues; or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof, are also covered.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:

- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;
- when confinement is intended solely to assist you, with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Spinal Manipulations

Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse and include the following:

- Inpatient hospital or substance abuse treatment facility services for detoxification
- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services
- Outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy.

When you are admitted to an out-of-network facility, *you are responsible* for notifying HMS of your admission. However, when you are admitted to a PPO network facility, the provider will contact HMS for authorization of your care.

Surgical Services

This program covers the following services you receive from a professional provider. If you use an out-of-network professional provider and an inpatient hospital admission is required, you must contact HMS prior to your admission.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery.

Your condition or the type of surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a professional provider who himself performs and bills for another surgical procedure during the same operative session.

Second Surgical Opinion

A consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;

- elective surgery is a covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is your option;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
- if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Special Surgery

- Sterilization

  Sterilization and its reversal regardless of medical necessity and appropriateness.

- Oral surgery

  Benefits are provided for the following limited oral surgical procedures determined to be medically necessary and appropriate:

  – Extraction of impacted third molars when partially or totally covered by bone

  – Extraction of teeth in preparation for radiation therapy

  – Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures

  – Mandibular frenectomy

  – Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition

  – Accidental injury to the jaw or structures contiguous to the jaw

  – The correction of a non-dental physiological condition which has resulted in a severe functional impairment

  – Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

  - Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- Mastectomy and Breast Cancer Reconstruction

  Benefits are provided for a mastectomy performed on an inpatient or outpatient basis and for the following:

  - Surgery to re-establish symmetry or alleviate functional impairment including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.
  - Initial and subsequent prosthetic devices to replace the removed breast or portions thereof
  - Physical complications of all stages of mastectomy, including lymphedemas

  Benefits are also provided for one home health care visit, as determined by your physician, within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where Highmark deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

Benefits will be provided for the following services when such services are ordered by a physician:

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment
- Infusion therapy when performed by a facility provider and for self-administration if the components are furnished and billed by a facility provider

- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

Transplant Services

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to transplantation of organs, bones, tissue or blood stem cells.

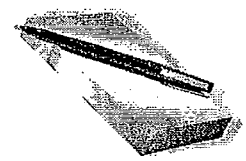
If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of this program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

What Is Not Covered

Your program will not provide benefits for services, supplies or charges:

- Which are not medically necessary and appropriate as determined by Highmark Blue Shield;
- Which are not prescribed by or performed by or upon the direction of a professional provider;
- Rendered by other than facility providers, professional providers or suppliers;
- Which are experimental/investigative in nature;
- Rendered prior to your effective date of coverage;
- Incurred after the date of termination of your coverage except as provided herein;
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
- For which you would have no legal obligation to pay;
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Unless the group is otherwise obligated by federal law to offer you all of the benefits of this program, to the extent payment has or would have been made by Medicare (both Parts A and B) regardless of whether you applied for such Medicare benefits. Accordingly, unless otherwise required by federal law, this program will provide you with supplemental benefits only (i.e., Medicare benefits will be taken into account when calculating the payment of your benefits);
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation;
- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay;
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary

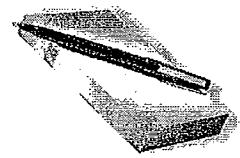


medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;

- For prescription drugs and medications, except those which are administered to an inpatient in a facility provider;
- For nicotine cessation support programs and/or classes;
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur;
- Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member;
- Rendered by a provider who is a member of your immediate family;
- Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;
- For ambulance services, except as provided herein;
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider;
- For inpatient admissions which are primarily for diagnostic studies;
- For inpatient admissions which are primarily for physical medicine services;
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
- For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: Dietitian services, Homemaker services, Maintenance therapy, Dialysis treatment, Custodial care, Food or home-delivered meals;
- For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is

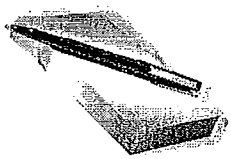
intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness;

- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein;
- For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein;
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
- For contraceptive devices and contraceptive implants, including services related to the provision of such devices or implants;
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial



keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services;

- For nutritional counseling, except as provided herein;
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;
- For treatment of obesity, except for medical and surgical treatment of morbid obesity or as provided herein;
- For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law;
- For well-baby care visits, except as provided herein;
- For routine neonatal circumcision;
- For allergy testing, except as provided herein or as mandated by law;
- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law;
- For immunizations required for foreign travel or employment;
- For the treatment of sexual dysfunction that is not related to organic disease or injury;
- For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services



provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time;

- For any care, treatment, or service which has been disallowed under the provisions of the Healthcare Management program;
- For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;
- For any illness or injury suffered during your commission of a felony;
- For any other medical or dental service or treatment or prescription drugs except as provided herein or as mandated by law.

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How PPOBlue Works

Your PPO program lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care services: **network** or **out-of-network.**

Network Care

Network care is care you receive from providers in the PPO program's network.

When you receive health care within the PPO network, you enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the PPO network.

Even when you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, you may need to obtain precertification from Highmark before services are received. For specific details, see your Summary of Benefits.

You may be responsible for paying any difference between the provider's actual charge and the PPOBlue program's payment.

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *even if you are directed to an out-of-network provider by a network provider.* **That's why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.**

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Shield PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Shield PPO network, these services will be covered at the lower level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Shield PPO network. If the treatment results in an admission, you need to obtain precertification from Highmark. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

The BlueCard Worldwide® Program

Your coverage also travels abroad. The Blue Shield symbol on your ID card is recognized around the world. That is important protection. PPOBlue provides all of the services of the BlueCard Worldwide Program. These services include access to a worldwide network of health care providers. Medical Assistance services are included as well. You can access these services by calling 1-800-810-BLUE or by logging onto www.bcbs.com.

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

Your Provider Network

Your PPO provider network is your key to receiving the higher level of benefits. The network includes: primary care physicians; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories in the Highmark managed care network service area.

This provider network is large, so chances are very good that your favorite doctor and your local hospital are in the network. To determine if your physician is in the network, refer to your physician directory, call the Member Service toll-free telephone number on the back of your ID card, or log onto www.highmarkblueshield.com.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. We consider educational background, office procedures and performance history to determine eligibility. Then we monitor care on an ongoing basis through office record reviews and patient satisfaction surveys.

Please note that while you or a family member can use the services of any network physician or specialist and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises.

Remember:
If you want to enjoy the higher level of coverage, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists.

Facility Providers

- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility

- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Hospital
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Psychiatric hospital
- Rehabilitation hospital
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed practical nurse
- Nurse-midwife
- Occupational therapist**
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Respiratory therapist**
- Speech-language pathologist
- Teacher of hearing impaired

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

**Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.*

***Covered services must be prescribed by a physician. Services of an occupational therapist and respiratory therapist are only reimbursable through a facility provider.*

Healthcare Management

Medical Management

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

Healthcare Management Services (HMS), or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

An HMS nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

Network Care
When you use a network provider for inpatient care, the provider will contact HMS for you to receive authorization for your care.

Out-of-Network Care or Out-of-Area Care
When you are admitted to an out-of-network or out-of-area facility provider, ***you are responsible*** for notifying HMS of your admission. However, some facility providers will contact HMS and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for preauthorization. If not, you are responsible for contacting HMS.

You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify HMS of your admission to an out-of-network facility provider, HMS may review your care after services are received to determine if it was medically necessary and appropriate. If your admission is determined not to be medically necessary and appropriate, **you will be responsible for all costs not covered by your program.**

Remember:
Out-of-network providers are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Healthcare Management Services' Care Utilization Review Process

In order to assess whether care is provided in the appropriate setting, HMS administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, HMS assists hospitals with discharge planning. These activities are conducted by an HMS nurse working with a physician advisor. Here is a brief description of these review procedures:

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, HMS:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, HMS will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Procedure or Covered Service Precertification

Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by Highmark. Network providers in the network service area and the Highmark managed care network service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

Case Management Services

Should you experience a serious injury or illness, or need assistance in coordinating your care needs, the Case Management program may be able to provide assistance.

If accepted into the program, and with your permission, the program will:

- work collaboratively with you, your family or significant others, and all your providers to coordinate and implement a plan of care which meets your holistic needs;
- help identify community-based support and educational services to assist with your ongoing health care needs; and
- assist in the coordination of benefits and alternative resources.

Precertification, Preauthorization and Pre-Service Claims Review Processes

Authorized Representatives

You have the right to designate an authorized representative to file or pursue a request for precertification or other pre-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by Highmark will, in the case of an urgent care claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim. However, this 15-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

Decisions Involving Urgent Care Claims

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim not later than 72 hours following receipt of the claim.

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, you will be notified within 24 hours following Highmark's receipt of your claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, Highmark will notify you of its decision concerning your urgent care claim seeking to extend that course of treatment not later than 24 hours following receipt of your claim.

Notices of Determination Involving Precertification Requests and Other Pre-Service Claims

Any time your request for precertification or any other pre-service claim is approved, you will be notified in writing that your claim has been approved. If your request for precertification or approval of any other pre-service claim has

been denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse determination involving a request for precertification or any other pre-service claim, see the Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse
- Unmarried children under 19 years of age, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court
- Unmarried children up to the age of 25, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support. Coverage automatically terminates at the end of the month in which the student is no longer a full-time student, whether or not notice to terminate is received by Highmark.
- Unmarried children over age 19 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability.

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Changes must be reported within 31 days of their occurrence.

Medicare

Retirees or Dependents

If you or a dependent are entitled to Medicare benefits (either due to age or disability) your program will not duplicate payments or benefits provided under Medicare. However, your program may supplement the Medicare benefits, including the deductible and coinsurance not covered by Medicare, provided the services are eligible under your group's program. Contact your Personnel Department for specific details.

The deductible and coinsurance will not be covered if the services are not covered under your Highmark program, even if they are covered under Medicare.

Continuation of Coverage

In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain church employers) who normally employed at least 20 or more employees in the prior calendar year, to extend temporary health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

Contact your employer for more information about COBRA and the events that may allow you or your dependents to temporarily extend health care coverage.

Certificates of Creditable Coverage

Your employer or insurance company is required to issue a certificate to you if you change jobs or lose your health care coverage. This Certificate of Coverage provides evidence of your prior coverage.

Certificates will be mailed automatically to everyone who changes or loses their health coverage. You can also request a certificate from your previous employer or insurance company.

Termination of Your Coverage Under the Employer Contract

Your coverage will be terminated when you cease to be eligible to participate under your group health plan in accordance with its terms and conditions for eligibility.

Benefits After Termination of Coverage

If you are totally disabled at the time your coverage terminates due to termination of active employment, benefits will be continued for covered services directly related to the condition causing such total disability. This benefit extension does

not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:

- Up to a maximum period of 12 consecutive months
- Until the maximum amount of benefits has been paid
- Until the total disability ends
- Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first

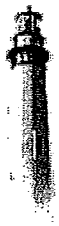
Your benefits will not be continued if your coverage is terminated because you failed to pay any required premium.

Coordination of Benefits

Most health care programs, including your PPOBlue program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
  - The parent with custody of the child pays first.



  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  - the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
  - the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Subrogation

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, your program has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

Your program will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support your program in any subrogation efforts.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

BlueCard® Program

When a member obtains covered services through BlueCard outside the geographic area Highmark serves, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (Host Blue) passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with a member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount a member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, Highmark would then calculate a member's liability for any covered services in accordance with the applicable state statute in effect at the time a member received care.

A Recognized Identification Card

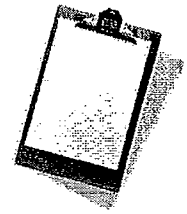
The Blue Shield symbol on your identification (ID) card is recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by logging onto www.highmarkblueshield.com.

Below is a sample of the type of information that will be displayed on your ID card:

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Member Service toll-free number (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- "PPO in Suitcase" symbol

There is a logo of a suitcase with "PPO" inside it on your ID card. This PPO suitcase logo lets hospitals and doctors know that you are a member of a Blue Shield PPO, and that you have access to PPO providers nationwide.



How to File a Claim

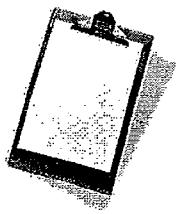
If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

The procedure is simple. Just take the following steps.

- ***Know Your Benefits.*** Review this information to see if the services you received are eligible under your medical program.
- ***Get an Itemized Bill.*** Itemized bills must include:
  - The name and address of the service provider;
  - The patient's full name;
  - The date of service or supply;
  - A description of the service or supply;
  - The amount charged;
  - The diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day, shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage;
  - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

  Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, through the Highmark Blue Shield Web site at*



www.highmarkblueshield.com, or call the Member Service telephone number on the back of your ID card.

- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the form.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

Your medical claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

Your Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement lists: the provider's charge; allowable amount; copayment; deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Filing Benefit Claims

- ***Authorized Representatives***

  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark Blue Shield reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claims***

  For a description of how to file a request for precertification or other pre-service claim, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

– ***Requests for Reimbursement and Other Post-Service Claims***

When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider's agreement with Highmark or the local licensee of the Blue Cross and Blue Shield Association serving your area. Highmark will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark. For instructions on how to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

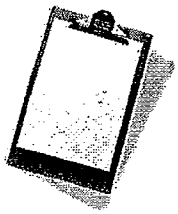
Determinations on Benefit Claims

– ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***

For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

– ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.



If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Appeal Procedure

Your benefit program maintains an appeal process. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

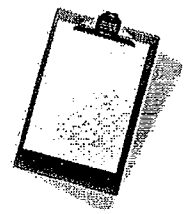
At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID Card to inquire about the filing or status of your appeal.

Initial Review

If you receive notification that a claim has been denied by Highmark , in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

The appeal will be reviewed by a representative from the Appeal Review Department. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of



your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. the Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

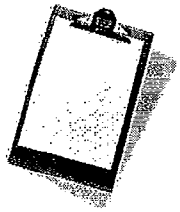
- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision, and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a claim is voluntary. In other words, you are not required to pursue the second level review of a claim



before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial level review of your appeal, you may request to have the decision reviewed by your plan sponsor in accordance with procedures established for your benefit program.

Member Service

Good health care is more than just doctor visits. It's also the service that supports your care.

For most of us, life is more hectic than ever. There just are not enough hours in the day. Therefore, we offer you the opportunity to get answers to your health care questions 24 hours a day, seven days a week.

Blues On Call℠

Blues On Call, our comprehensive health information and support program, provides you with up-to-date, easy to understand information about medical conditions and treatment options.

A registered nurse Health Coach is available online at the Highmark Blue Shield Web site or at a toll-free telephone number -- 1-888-BLUE-428 -- 24 hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans to improve your health outcomes. Using the patient-centered approach, Shared Decision-Making, Blues On Call offers three levels of health coaching and support:

- General information and support regarding medical procedures, treatment decisions and questions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics and targeted mailings of printed materials
- Treatment decision support for making medical and surgical decisions that reflect personal values and preferences, talking with physicians regarding treatment options, and receiving ongoing support and follow-up throughout treatment plans, plus links to information sources, free videotapes and Web-based education
- Chronic condition management for those at greater risk for hospitalization, complications or an increase in the severity of their disease, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources, such as case managers, home health services, community resources or Employee Assistance Programs. Blues On Call also provides targeted mailings relative to specific risks, free equipment or tools to support self-management goals and help to improve clinical and quality of life outcomes and reduce ongoing risks associated with chronic disease.

Member Services

Whether it's for help with a claim or a question about your benefits, you can call your Member Service toll-free telephone number on the back of your ID card or log onto Highmark Blue Shield's Web site, www.highmarkblueshield.com. A Highmark Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

Highmark's Web site

The Highmark Blue Shield Web site, www.highmarkblueshield.com, engages employees in their coverage, care and health. By logging onto the site, you can manage your coverage more efficiently and make more informed, appropriate and affordable health care decisions.

Online "self-service" tools let you:

- Locate network physicians and pharmacies
- Get prescription drug pricing information
- Review Preventive Care Guidelines
- Access Highmark's R_x formulary
- Refill mail order prescriptions
- Check eligibility information
- Order ID cards
- Order medical or drug claim forms

Online health tools let you:

- Learn your health status and identify goals for health improvement
- Refer to the comprehensive, full-color Health Encyclopedia
- Access the Healthwise Knowledgebase with information on every kind of medical condition
- Take Lifestyle Improvement courses on stress management, smoking cessation and nutrition
- Use Health Crossroads to access treatment options for conditions such as back pain, breast cancer and coronary artery disease
- Look up information on every type of health condition in Patient Guides
- Follow step-by-step Care Guides for a variety of conditions, including high cholesterol and high blood pressure
- E-mail Blues On Call for confidential health decision support from a specially-trained Health Coach

Online cost and quality tools help you:

- Look up typical medical expenses using Cost by Condition and Price by Procedure Guides

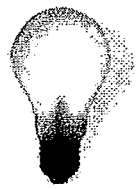
- Keep track of your care expenses conveniently through My Expense Summary
- Review claims and EOB information
- Access provider quality information, such as how well hospitals care for patients with certain medical conditions and how often providers perform certain care services

Health and Wellness Bus

Our multi-graphics bus takes health screenings and education and immunizations into communities or worksites. Board the bus at work or in your neighborhood!

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark's Member Service representatives are trained to make the connection.



Terms You Should Know

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

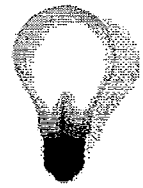
BlueCard Program - A program comprised of licensees of the Blue Cross and Blue Shield Association which allows a member to receive covered services from participating professional, contracting supplier and participating facility providers located out-of-area. The local licensee of the Blue Cross and Blue Shield Association that services that geographic area where the covered services are provided is referred to as the "on-site" licensee of the Blue Cross and Blue Shield Association.

Blues On Call - A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

Claim – A request for precertification or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.



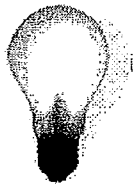
Designated Agent - An entity that has contracted with the health plan to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective for the condition being treated. An intervention is considered to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical Researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.



Highmark Managed Care Network Service Area - The geographic area consisting of the following counties in western Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter
Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

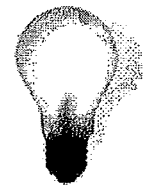
Infertility - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

Medically Necessary and Appropriate - Services or supplies provided by a facility provider or professional provider that are determined to be: (i) appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and (ii) provided for the diagnosis or the direct care and treatment of your condition, illness, disease or injury; and (iii) provided in accordance with standards of good medical practice; and (iv) not primarily for your or your provider's convenience; and (v) the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition, and you cannot receive safe or adequate care as an outpatient.

Methadone Maintenance - The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

Network Service Area - The geographic area consisting of the following counties in Pennsylvania:

Adams	Franklin	Lehigh	Perry
Berks	Fulton	Mifflin	Schuylkill
Centre (part)	Juniata	Montour	Snyder
Columbia	Lancaster	Northampton	Union



Cumberland Lebanon Northumberland York
Dauphin

Plan - Refers to Highmark Blue Shield, which is an independent licensee of the Blue Cross and Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted to perform a function or service in the administration of this program.

Precertification (Preauthorization) - The process through which selected covered services are pre-approved by Highmark.

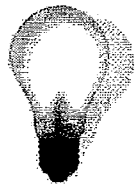
Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care physician, but is based on a provider network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Reasonable Charge ***(also called "Allowable Charge")*** - The allowance or payment that is determined to be reasonable for covered services based on the provider who renders such services. The PRC is the portion of the provider's billed charge that is used to calculate the payment to that provider and your liability.

Specialist - A physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are



substantially unable to engage in the normal activities of an individual of the same age and sex.

You or Your - Refers to individuals who are covered under the program.

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark, we are committed to protecting the privacy of your protected health information. "Protected health information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

We will inform you of these practices the first time you become a Highmark Inc. customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations
We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business and the like.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates.
In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.
In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. **Required by Law**
We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. **Public Health Activities**
We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. **Health Oversight Activities**
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. **Abuse or Neglect**
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. **Legal Proceedings**
We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. **Law Enforcement**
Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. **Research**

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. **To Prevent a Serious Threat to Health or Safety**

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. **Military Activity and National Security, Protective Services**

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. **Inmates**

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. **Workers' Compensation**

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. **Others Involved in Your Health Care**

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record

set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center

Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH – BLILEY)

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark customer and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as

necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

HIGHMARK®
BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association